MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 18, 2001
10:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
Public comment

MS. MCELRATH: I'm Sharon McElrath with the American Medical Association. I just would like to say, I don't think you really should be very sanguine about the access issue. The survey that was done by Project HOPE that was done in 1999 was looking at what happened in '98. That was one year after the BBA. The only one of the physician changes that has occurred over the last several years that had happened at that point was to go to a single conversion factor. You did not have any of the practice expense changes.

You are looking at some physicians that have seen over 50 percent cut over the last 10 years in what their payments are for some procedures. If you put a 5 percent cut on top of that -- and maybe it's going to be something less than that -- but I think you really do have to be concerned.

The other thing is on the participation number, the 88 percent, one of the things that happens is as you have people dropping out, the people who dropped out more frequently, or the ones who drop out first, are the people who were non-participating physicians. So as that happens, your participating physician, the agreement actually goes up and it looks better.

As to the 3.5, probably some of that is data cleaning. But to the extent that it's people taking out numbers that aren't being used and that once were being used, it does seem to indicate that there's something going on there. We do have reports in any number of -- I mean, there are newspaper reports from Spokane, Denver, Atlanta, Austin, a lot of different places in the country now where there are reports of people having trouble getting a physician to take a Medicare patient. So I just would like to say that letting it just go ahead and take effect I don't think is a great option.

MR. LEEDY: Good afternoon. My name is Don Leedy and I am the chief operating officer for the Fox Chase Cancer Center in Philadelphia. I just thought I would like to offer some commentary on some of the points raised earlier in the meeting.

The freestanding cancer centers have existed since 1983 based on criteria established by HCFA, now CMS, fundamentally looking at institutions who have the majority of their discharges in cancer. So since 1983, Fox Chase has been an exempt center. The 11 centers are geographically dispersed over eight states. We are not governed in any fashion by each other, and we come together from time to time to study issues that affect all of us.

Our analysis early on of the APG system, and ultimately the APC system, indicated to us that the system is flawed in how it pays for cancer care regardless of setting. I agree with Dr. Rowe that high quality cancer care is rendered in many, many institutions and all institutions are disadvantaged by this current system.

The difference with the exempt centers has to do with two fundamental points. Ninety-five to 98 percent of our business is cancer care. We have no other diseases to make some money off of

to offset these losses. I believe that that is true in other areas. And because of the inpatient exemption, we also generate no margin.

When we looked at the issue, Congress was very nice and recognized the problem and extended the exemption in the form of a hold-harmless into the outpatient setting. This had the advantage of alleviating the problem, but also solved an issue that medical decisions as to where cancer care should be rendered would not be impacted by whether or not it would be advantageous to treat somebody on an inpatient or an outpatient basis. We've tried to provide data to MedPAC staff, and we will continue to do that.

Why this issue is particularly important to us is that cancer care has shifted from an inpatient treatment setting to an outpatient treatment setting. In 1996, Fox Chase rendered about 60 percent of cancer care on an inpatient setting and 40 percent on an outpatient. That has now shifted to 40 percent, 60 percent, and is likely to continue in that. My sense of the data from the other centers is that it's quite similar. If you look at somebody like Dana Farber, they're 20 percent inpatient, 80 percent outpatient, so it's really hard to make a shift.

We believe that this hold harmless is critical to the centers. We would like to cooperate with staff and the Commission to provide you whatever information that you need.

Thank you.

MR CONNELLY: Good afternoon, members of the Commission. My name is Jerry Connelly. I'm with the American Academy of Family Physicians.

I'd like to just mention relative to the last issue that you dealt with, the payment update for physician services, and point out that, let's just say that the estimate, the revised estimate for 2002 of negative 4.5 percent is accurate, just for the sake of discussion. If it is, then over the course of the four years in which the SGR has been in effect, the average increase of an update would be about 1.8 percent; the average increase, 1.8 percent per year. Combine that with the data that we have from the MGMA that indicates that on the average costs of running a physician's office escalate 5 to 6 percent, you're putting these practitioners in a hole of 3 or 4 percent per year for the last four years, an the aggregate.

I'd also like to address the issue of access because I think it's extremely important at this point in time. Family physicians are in the forefront of the access issue, particularly at this time when we have a shortage of vaccine, of flu vaccine, we have depression issues relative to the most recent crisis that this nation is facing. We have now the prospects of bioterrorism and people interested in and requiring antibiotics, and therefore requiring physician services.

All these issues, I think paint a very important picture for you to take into consideration today relative to the physician and what Congress can do and what CMS can do relative to this update. Because of these and the other concerns that you've articulated -- and I know you're wrestling with this as we are -- that I would really encourage your strong consideration of

issuing a recommendation to freeze, or at least not issue a change in the update for this year, along with a commitment which apparently is -- I think this group and others are far along on the trail of trying to change this and committing to change this SGR system, that those two issues be combined into a recommendation. That is that there's a freeze for 2002 and a commitment to revise the SGR formula.

Thank you.

MR. MAY: Hi, my name is Don May from the American Hospital Association. Thank you for the opportunity to comment, and thank Jack and his staff for all the good work they do. We really appreciate it.

Just two quick points. First on the payment adequacy discussion. We're encouraged by some of the additional analyses that the staff are proposing. However, we do want to reiterate, I think what Dr. Newhouse said, and caution setting a target for the aggregate margin. There are lots of important things in looking at hospital performance, and when it comes to doing updates, setting a target margin may overwhelm some of the other important things, the other financial ratios, access to patient care, things such as that.

The second point is on the update discussion. In particular, concern about the recommendation to consider other factors only if they are expected to significantly affect providers' cost in reference to science and technological advances, productivity increases, and one-time factors. Over the last couple years we've had some very important factors that have been looked at and examined under that part of the framework. Things such as HIPAA, Y2K, new drugs and devices. All have been very important and they're not captured under the regular marketbasket discussion.

Not looking at them unless you think that it's significant becomes difficult. If you're not looking at them, how do you know if they're significant, number one? Secondly, I think that there's been -- as someone mentioned, they've been offsetting in the last couple year. Maybe part of the reason it has been offsetting is that there hasn't been the type of quantitative analysis in measuring these impacts that maybe was done in the past, as Dr. Newhouse mentioned, when Project HOPE did these specific analyses. We might recommend doing a more quantitative approach measuring these impacts versus not looking at them more closely.

Thank you.

MR. FAY: Hi, my name is Tony Fay. I'm with Province Health Care. We manage 57 rural hospitals in 20 different states. I just wanted to make a brief point, and that is the point that the physician fee schedule is also used as the basis of payment for physical therapy, occupational therapy, and speech pathology services as well as nurse practitioner services. So therefore, the SGR concept affects the payments to those individuals and also the hospitals that employ those individuals.

Thank you.

MR. HACKBARTH: Anyone else?

Okay, thank you all. We reconvene at 9:00 a.m. tomorrow,

sharp.

[Whereupon, at 4:34 p.m., the meeting was recessed, to reconvene at 9:00 a.m., Friday, October 19, 2001.]